

E-021-18

ORIGINAL

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**RECEIVED****This Section must be completed for all projects.**

APR 23 2018

Facility/Project Identification

Facility Name: Prairie Diagnostic Center at St. John's Hospital- Discontinuation of Prairie Diagnostic Center ("ASTC")		
Street Address: 401 E. Carpenter Street		
City and Zip Code: Springfield, 62702		
County: Sangamon	Health Service Area: 3	Health Planning Area: E-01

HEALTH FACILITIES &
SERVICES REVIEW BOARD**Applicant(s)** [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: St. John's Hospital of the Hospital Sisters of the Third Order of Saint Francis d/b/a Prairie Diagnostic Center at St. John's Hospital	
Street Address: 800 E. Carpenter Street	
City and Zip Code: Springfield, 62769	
Name of Registered Agent: Amy K. Bulpitt	
Registered Agent Street Address: 800 E. Carpenter Street	
Registered Agent City and Zip Code: Springfield, 62769	
Name of Chief Executive Officer: Dr. Charles Lucore	
CEO Street Address: 800 E. Carpenter Street	
CEO City and Zip Code: Springfield, 62769	
CEO Telephone Number: (217) 535-3989	

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Other	

- Corporations and limited liability companies must provide an Illinois certificate of good standing.
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Clare Connor
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cconnor@mwe.com
Fax Number: (312) 277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name: NONE

Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**This Section must be completed for all projects.****Facility/Project Identification**

Facility Name: : Prairie Diagnostic Center at St. John's Hospital- Discontinuation of Prairie Diagnostic Center ("ASTC")		
Street Address: 401 E. Carpenter Street		
City and Zip Code: Springfield, 62702		
County: Sangamon	Health Service Area: 3	Health Planning Area: E-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Hospital Sisters Services, Inc.
Street Address: 4936 Laverna Road
City and Zip Code: Springfield, 62707
Name of Registered Agent: Amy K. Bulpitt
Registered Agent Street Address: 4936 Laverna Road
Registered Agent City and Zip Code: Springfield, 62707
Name of Chief Executive Officer: Mary Starmann-Harrison
CEO Street Address: 4936 Laverna Road
CEO City and Zip Code: Springfield, 62707
CEO Telephone Number: (217) 788-6288

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other

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Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cconnor@mwe.com
Fax Number: (312) 277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name: NONE
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:

Fax Number:

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: : Prairie Diagnostic Center at St. John's Hospital- Discontinuation of Prairie Diagnostic Center ("ASTC")		
Street Address: 401 E. Carpenter Street		
City and Zip Code: Springfield, 62702		
County: Sangamon	Health Service Area: 3	Health Planning Area: E-01

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Hospital Sisters Health System
Street Address: 4936 Laverna Road
City and Zip Code: Springfield, 62707
Name of Registered Agent: Amy K. Bulpitt
Registered Agent Street Address: 4936 Laverna Road
Registered Agent City and Zip Code: Springfield, 62707
Name of Chief Executive Officer: Mary Starmann-Harrison
CEO Street Address: 4936 Laverna Road
CEO City and Zip Code: Springfield, 62707
CEO Telephone Number: (217) 788-6288

Type of Ownership of Applicants

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<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
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<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois certificate of good standing.o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.		
APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Clare Connor
Title: Partner
Company Name: McDermott Will & Emery LLP
Address: 227 W. Monroe Street, Chicago, IL 60606
Telephone Number: (312) 984-3365
E-mail Address: cconnor@mwe.com
Fax Number: (312) 277-2964

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

Name: NONE
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]**

Name: Amy Bulpitt
Title: Senior Vice President and General Counsel
Company Name: Hospital Sisters Health System
Address: 800 E. Carpenter Street, Springfield, IL 62769
Telephone Number: (217) 814-8336
E-mail Address: Amy.Bulpitt@hshs.org
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: St. John's Hospital of the Hospital Sisters of the Third Order of St. Francis
Address of Site Owner: 800 E. Carpenter Street, Springfield, IL 62769
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: St. John's Hospital of the Hospital Sisters of the Third Order of St. Francis	
Address: 800 E. Carpenter Street, Springfield, IL 62769	
<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements**N/A-Discontinuation**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 ([http:// www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements**N/A Discontinuation**

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms, NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

HSHS St. John's Hospital proposes the discontinuation of Prairie Diagnostic Center at St. John's Hospital, a single specialty ambulatory surgical treatment center ("ASTC"). Prairie Diagnostic Center has two procedure rooms and has temporarily discontinued performing cardiac catheterization procedures, in accordance with the Illinois Health Facilities and Services Review Board ("HFSRB") rules, pending approval by the HFSRB of permanent discontinuation.

This project does not include the construction, demolition, or modernization of any existing buildings and there are no project costs.

This is a substantive project because it proposes the discontinuation of a health care facility.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	N/A	N/A	N/A
Site Survey and Soil Investigation	N/A	N/A	N/A
Site Preparation	N/A	N/A	N/A
Off Site Work	N/A	N/A	N/A
New Construction Contracts	N/A	N/A	N/A
Modernization Contracts	N/A	N/A	N/A
Contingencies	N/A	N/A	N/A
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	N/A	N/A	N/A
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space or Equipment	N/A	N/A	N/A
Other Costs To Be Capitalized	N/A	N/A	N/A
Acquisition of Building or Other Property (excluding land)	N/A	N/A	N/A
TOTAL USES OF FUNDS	N/A	N/A	N/A
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	N/A	N/A	N/A
Pledges	N/A	N/A	N/A
Gifts and Bequests	N/A	N/A	N/A
Bond Issues (project related)	N/A	N/A	N/A
Mortgages	N/A	N/A	N/A
Leases (fair market value)	N/A	N/A	N/A
Governmental Appropriations	N/A	N/A	N/A
Grants	N/A	N/A	N/A
Other Funds and Sources	N/A	N/A	N/A
TOTAL SOURCES OF FUNDS	N/A	N/A	N/A
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>N/A</u> .		

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.	
Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>Within (30) days from Exemption Approval</u>	
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): N/A- No project costs; Discontinuation	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed. <input type="checkbox"/> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies	
<input type="checkbox"/> Financial Commitment will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
<input checked="" type="checkbox"/> Cancer Registry
<input checked="" type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of St. John's Hospital of the Hospital Sisters of the Third Order of St. Francis* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.



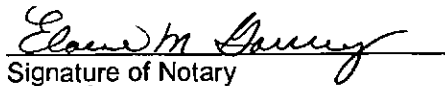
SIGNATURE

Charles Lucore, M.D.
PRINTED NAME

CEO
PRINTED TITLE

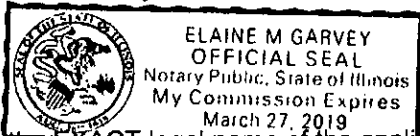
Notarization:

Subscribed and sworn to before me
this 5th day of April, 2018



Signature of Notary

Seal



*Insert the EXACT legal name of the applicant



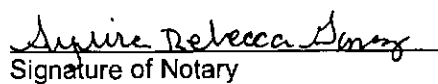
SIGNATURE

Ann Carr
PRINTED NAME

Treasurer
PRINTED TITLE

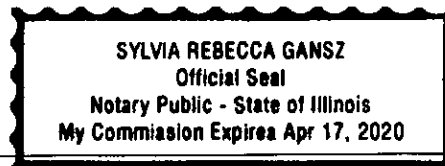
Notarization:

Subscribed and sworn to before me
this 6th day of April, 2018



Signature of Notary

Seal



CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Hospital Sisters Services, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

Mary Starmann-Harrison
SIGNATURE

Mary Starmann-Harrison
PRINTED NAME

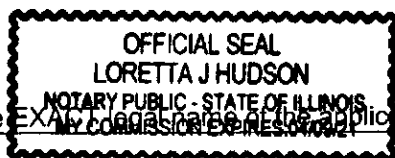
CEO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of April, 2018

Loretta J. Hudson
Signature of Notary

Seal



*Insert the EX-17 of the applicant

Ann Carr
SIGNATURE

Ann Carr
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 6th day of April, 2018

Sylvia Rebecca Gansz
Signature of Notary

Seal



CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:


- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Hospital Sisters Health System* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

Mary Starmann-Harrison
PRINTED NAME

CEO
PRINTED TITLE

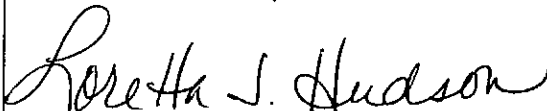

SIGNATURE

Ann Carr
PRINTED NAME

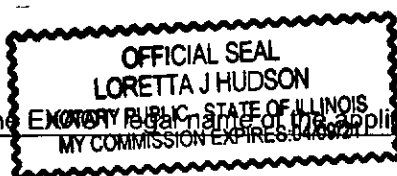
Treasurer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9th day of April, 2018


Signature of Notary

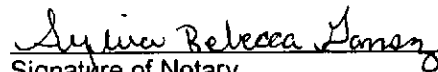
Seal



*Insert the EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 6th day of April, 2018


Signature of Notary

Seal



SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

- | |
|--|
| <input checked="checked" type="checkbox"/> Discontinuation of an Existing Health Care Facility |
| <input type="checkbox"/> Discontinuation of a category of service |

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written,

or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
Inpatient			

	Outpatient			
	Total			

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

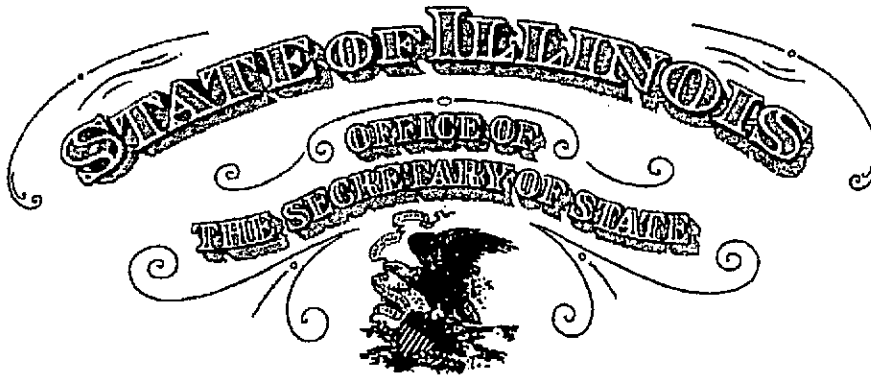
INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	19-21
2	Site Ownership	22-26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	N/A
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	27-28
5	Flood Plain Requirements	N/A
6	Historic Preservation Act Requirements	N/A
7	Project and Sources of Funds Itemization	N/A
8	Financial Commitment Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	29-30
11	Background of the Applicant	N/A
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
	Service Specific:	
14	Neonatal Intensive Care Services	N/A
15	Change of Ownership	N/A
	Financial and Economic Feasibility:	
16	Availability of Funds	N/A
17	Financial Waiver	N/A
18	Financial Viability	N/A
19	Economic Feasibility	N/A
20	Safety Net Impact Statement	31-32
21	Charity Care Information	33

Attachment 1- Applicant Identification Including Certificate of Good Standing

Hospital Sisters Health System

File Number

5163-355-5



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

HOSPITAL SISTERS HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 26, 1978, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1621602348 verifiable until 08/03/2017
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 3RD
day of AUGUST A.D. 2016 .

Jesse White

SECRETARY OF STATE

Attachment 1- Applicant Identification Including Certificate of Good Standing

Hospital Sisters Services, Inc.,

File Number

5325-639-2

***To all to whom these Presents Shall Come, Greeting:***

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

HOSPITAL SISTERS SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 04, 1983, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of AUGUST A.D. 2016 .

Authentication #: 1621602372 verifiable until 08/03/2017
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

Attachment 1- Applicant Identification Including Certificate of Good Standing

St. John's Hospital of The Hospital Sisters of The Third Order of St. Francis

File Number

3528-156-8



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ST. JOHN'S HOSPITAL OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1621602382 verifiable until 08/03/2017
Authenticate at: <http://www.cyberdriveillinois.com>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 3RD
day of AUGUST A.D. 2016 .***

Jesse White

SECRETARY OF STATE

Attachment 2- Site Ownership



Selected Parcel: 14-27.4-304-013

Location: 417 E CARPENTER ST

Current Assessment 2017 Payable 2018

Name & Mailing Address
ST JOHN'S HOSPITAL OF HOSPITAL
SISTERS OF 3RD OSF
800 E CARPENTER ST
SPRINGFIELD, IL 62702-5324

Class 60 IMPROVED COMMERCIAL

Status Active

Tax Code 093

Property Address
417 E CARPENTER ST
SPRINGFIELD, IL 62702

Legal Description
B 1 MARGARET B LINES ADDN E
L 2-14 HICKOX ADDN E PT VAC
ALLEY (47% TAXABLE PART
SEE POINT O NUMBER)

Exemptions
"None"

Non-Farm Acres 2.87 Farm Acres 0.00

Volume 7 Page 0

Assessment Values

	Prior Year Board of review Equalized	Assessor Changes	Board of Review Changes	Board of Review Equalized
		Finalized	Not Finalized	Not Finalized
Status	Active	Active		
Class	IMPROVED COMMERCIAL	IMPROVED COMMERCIAL		
Tax Code	093	093		
Reason				
Non-Farm Land	177,104	177,104		
Non-Farm Building	410,367	410,367		
Farm Land	0	0		
Farm Building	0	0		
1st Time Non-Farm Building	0	0		
1st Time Farm Building	0	0		
* TOTAL *	587,471	587,471		

Current Billing Details 2016 Payable 2017

Payment History, Year 2016 Payable 2017							
No	Date	Amount	Penalty	Other Costs	Transaction Type		
1	05/01/2017	48,992.74	0.00	0.00	Current	2016	Billed Airst
2	05/17/2017	-48,992.74	0.00	0.00	Current	2016	Pd PO Box

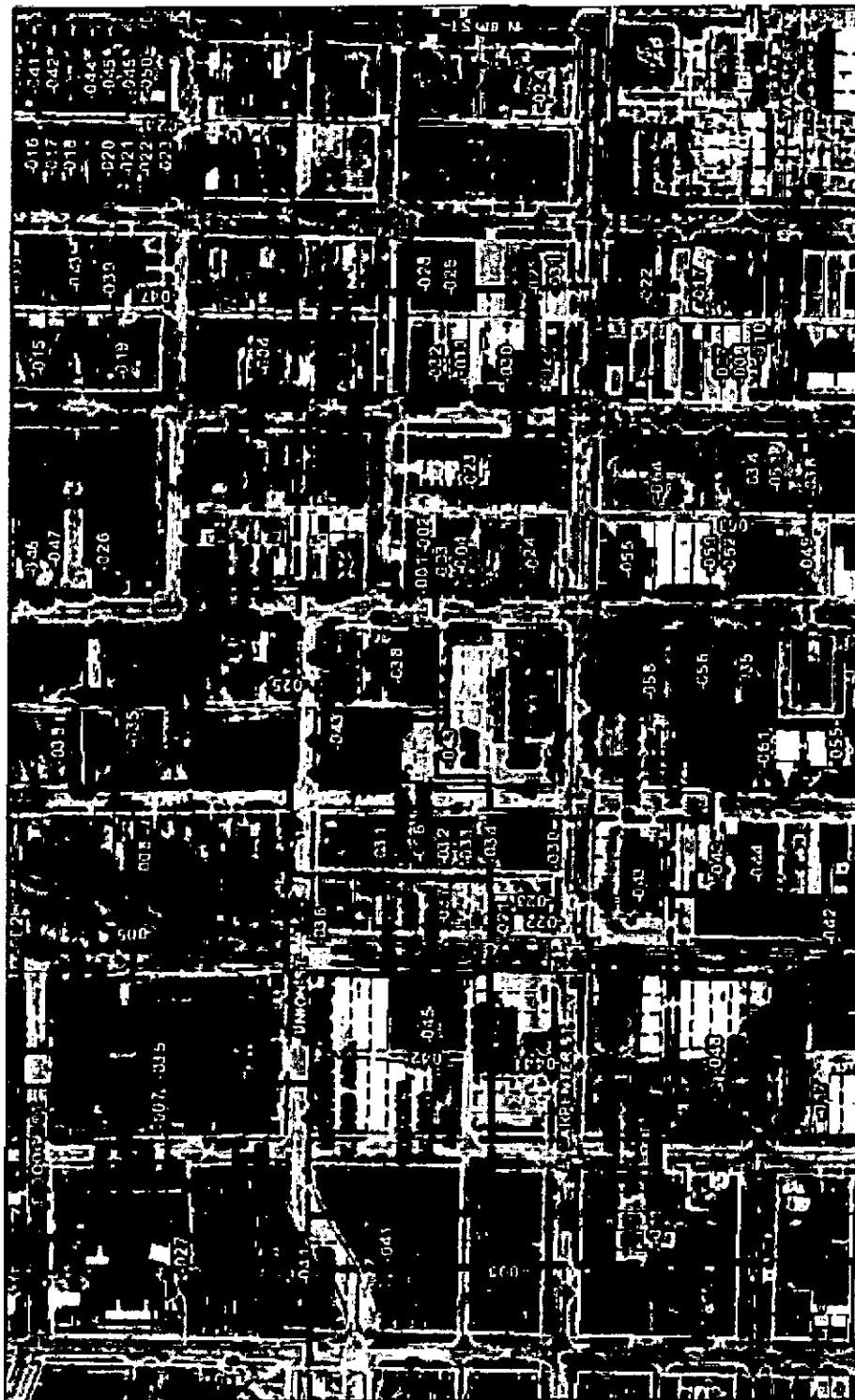
Assessment Information

Bill Information

Installment Details

Attachment 2- Site Ownership (Continued)

Assessment Year	2016-2017	Tax Year	2016-2017	1st Installment
Fair Market Value	1,762,413	Value After Exemptions	537,471	Due Date 08/09/2017
Assessed Value	500,448	Tax Rate	8.3396%	Tax Due \$0.00
Township Multiplier	1.0121	Tax Extended	\$48,992.74	2nd Installment
Value After Township Multiplier	537,471	Adjustments	\$0.00	Due Date 09/01/2017
County Multiplier	1.0000	Tax Billed	\$48,992.74	Tax Due \$0.00
Equalized Value	537,471	Payments	-\$48,992.74	No payments are currently scheduled.
Value After Exemptions	537,471			
		Tax Due	\$0.00	
		1st Installment	\$0.00	
		2nd Installment	\$0.00	

Attachment 2- Site Ownership (Continued)

March 14, 2018

Office Of

Supervisor of Assessments


Sangamon County GIS

Although strict accuracy standards have been employed in the completion of this map, Sargerson County does not warrant or guarantee the accuracy of the information contained herein and disclaims any and all liability resulting from any error or omission in the map.

contained herein and disclaims any and all liability resulting from any error or omission in this map.

Part Number: 1427504043
Quantity: 1

Certificate of Good Standing- Licensee

	Illinois Department of PUBLIC HEALTH	HF113788
LICENSE, PERMIT, CERTIFICATION, REGISTRATION		
The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.		
Nirav D. Shah, M.D.,J.D. Director		Issued under the authority of the Illinois Department of Public Health
EXPIRATION DATE 6/30/2018	CATEGORY	ID NUMBER 7003157
Ambulatory Surgery Treatment Center		
Effective: 07/01/2017		
Prairie Diagnostic Center at St. John's Hospital 401 E. Carpenter St. Springfield, IL 62702		
The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 SM 5/16		

Attachment 1- Applicant Identification Including Certificate of Good Standing

St. John's Hospital of The Hospital Sisters of The Third Order of St. Francis

File Number

3528-156-8



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ST. JOHN'S HOSPITAL OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 03, 1955, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1621602382-verifiable until 08/03/2017
Authenticate at: <http://www.cyberdriveillinois.com>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 3RD
day of AUGUST A.D. 2016 .***

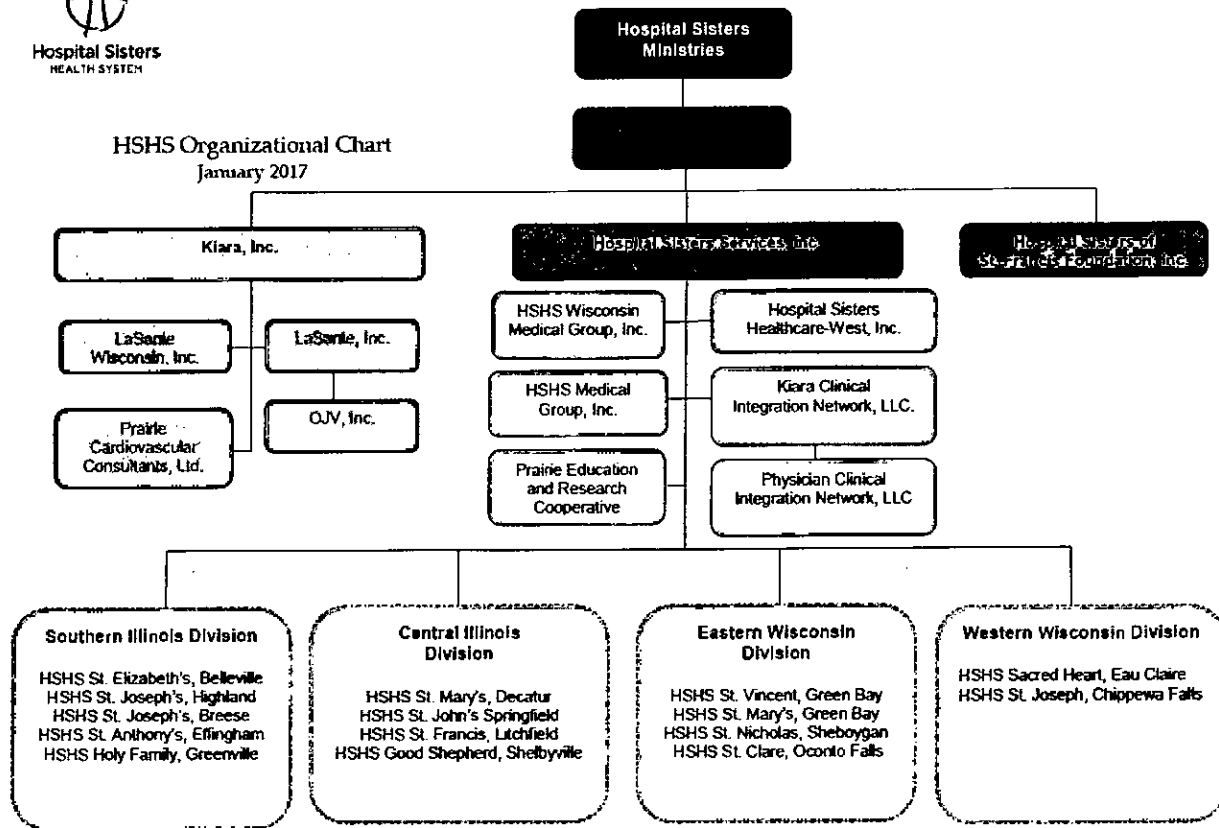
Jesse White

SECRETARY OF STATE

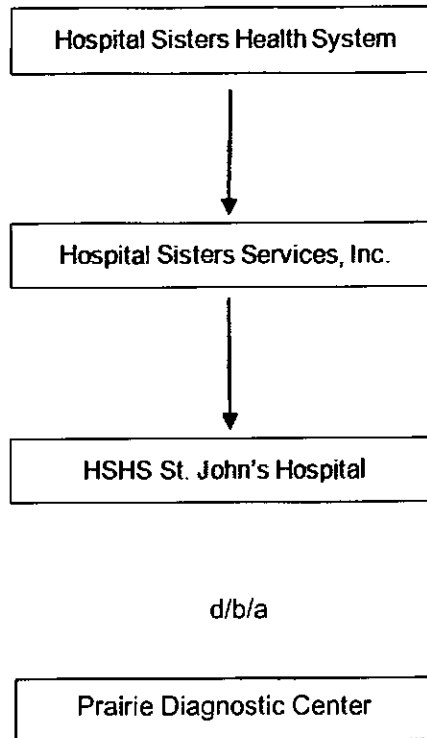
Attachment 4- Organizational Relationships (Organizational Chart)



HSBS Organizational Chart
January 2017



Attachment 4- Organizational Relationships



Attachment 10- Discontinuation**GENERAL INFORMATION REQUIREMENTS**

1. Identify the categories of service and the number of beds, if any that are to be discontinued.

The single specialty ambulatory surgery center (cardiac catheterization procedures) will be discontinued. No beds will be discontinued.

2. Identify all of the other clinical services that are to be discontinued.

No other clinical services will be discontinued.

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.

Shortly after approval, and HFSRB will be notified of the exact date of discontinuation.

4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.

Upon discontinuation of the surgical center, the facility will continue to operate as a non-surgical outpatient center for cardiovascular specialties.

5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.

The medical records of the surgery center will be maintained by St. John's Hospital in accordance with applicable State law.

6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

See Appendix A.

7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.

8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

See Appendix A.

Attachment 10- Discontinuation (Continued)**REASONS FOR DISCONTINUATION**

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

The utilization of the operating rooms at this facility to perform cardiac catheterization procedures has declined steadily to the point that keeping it open appears to be unnecessary, particularly as St. John's Hospital, which owns and operates the facility offers the cardiac catheterization service. There are 4 providers (including St. John's Hospital) that offer this surgical service within a 45-minute radius of the facility.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.

Given the declining volumes of cardiac catheterization procedures performed at the surgery center and the ample availability of alternate providers in the region, the applicants do not believe there will be any impact on the availability of the service to area residents.

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

See Appendix A.

Attachment 20- Safety Net Impact Statement

1.The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

The applicants believe that the availability of cardiac catheterization procedures in the service area is sufficient enough to ensure that this project will not have a material impact on essential safety net services in the community.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

The applicants believe that this project will not materially impact the ability of other providers or health care systems to subsidize safety net services due to the declining utilization of the surgery center and St. John's Hospital's ability to provide the services.

3.How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

The applicants believe that this discontinuation will not have an impact on area safety net providers.

Safety Net Impact Statements shall also include all of the following:

1.For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

See attached table below.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

See attached table below.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

None known.

A table in the following format must be provided as part of Attachment 40.

St. John's Hospital*

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year 2015	Year 2016	Year 2017
Inpatient	370	337	313
Outpatient	2,910	2,362	2,430
Total	3,280	2,699	2,743
Charity (cost in dollars)			
Inpatient	\$2,109,755	\$3,640,155	\$2,094,822
Outpatient	\$1,228,465	\$2,118,673	\$2,476,181
Total	\$3,338,220	\$5,758,828	\$4,571,002
MEDICAID			
Medicaid (# of patients)	Year 2015	Year 2016	Year 2017
Inpatient	5,958	5,833	5,879
Outpatient	54,500	55,576	51,185
Total	60,458	61,409	57,064
Medicaid (revenue)			
Inpatient	\$78,605,182	\$53,329,213	\$68,973,573
Outpatient	\$24,662,439	\$39,189,056	\$29,311,881
Total	\$103,267,621	\$92,518,269	\$98,285,454

Attachment 21- Charity Care Information

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

See table below. This table reflects charity care provided by the co-applicant Hospital Sisters Health System (Illinois only) and St. John's Hospital.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

See table below. This table reflects charity care provided by the co-applicant Hospital Sisters Health System (Illinois only).

4. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

N/A-Existing

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 41.

CHARITY CARE - St. John's Hospital			
	Year Ended 6/30/15	Year Ended 6/30/16	Year Ended 6/30/17
Net Patient Revenue	\$ 447,281,758	\$ 461,466,000	\$ 475,001,000
Amount of Charity Care (charges)	\$ 12,138,983	\$ 19,068,688	\$ 15,135,769
Cost of Charity Care	\$ 3,338,220	\$ 5,110,483	\$ 3,841,757

CHARITY CARE - HSHS Illinois Hospitals			
	Year Ended 6/30/15	Year Ended 6/30/16	Year Ended 6/30/17
Net Patient Revenue	\$1,262,757,958	\$1,027,791,000	\$1,089,209,000
Amount of Charity Care (charges)	\$ 49,555,376	\$ 59,665,591	\$ 52,040,415
Cost of Charity Care	\$ 20,025,778	\$16,672,211	\$ 15,165,565

Appendix A

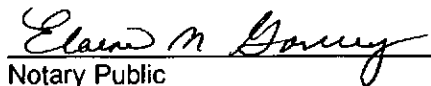
For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

All reports and responses to questionnaires required to be filed by the facility with the Illinois Department of Public Health are up to date and/or will be filed and up to date within ninety (90) days of the permanent discontinuation of the facility.

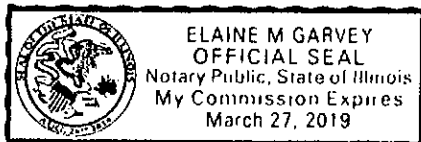


Charles L. Lucore, M.D., MBA
President & CEO, HSHS St. John's Hospital

Subscribed and sworn to before me this
5th day of April, 2018.



Notary Public



Appendix A - The state Journal register Published April 1, 2018

FOR RENT!
1129 E. Hickory
2 Br, 5550/mo+dep
217-553-4201

Out of Town

23481 Covered
Bridge Rd. Adams
2BR duplex, 1.5BA, 1
Cath, gar, new car-
pet & paint, all appls
3 W/O, Garbage
hookups, lawn main.
\$700/mo. Call: 217-
652-1887

INVERTED
Ecks Tack, large
2BR Apt. in quiet
Setting \$600/mo
Small pets ok
217-528-9673

Mobile Homes For
Sale

Big Creek
Easy financing
become a
NEW HOME OWNER
3-4 Bedrooms
217-717-9420

EASY to become a
HOMEOWNER!
3-4 Bedrooms
\$750-\$950
217-717-9420

April

April 15 Sun 10am
Home & 15 acres
13089 Becker St
Tallula, IL - Refrig,
mower, tractor,
horse trailer, carport,
+ more - Linda
Watts Owner
lukedeegates.com

Hay/Feed

Alfalfa Hay
\$5.00
Clean wheat
straw \$3.00
217-475-
2979

Lost

Lost Passport:
Springfield
Country #A5360662
Country Office Bq
Last seen
November/December
217-414-1809

Did you know...

14%
in the share of
newspaper revenue
now coming from digital



*AKC finished registration!
standard poodle puppies
\$600 males, \$700 for females
Please email of ad:
217-836-2400
mccallan@earthlink.net
for more information

Pets

LABS - GOLDADORS
LABRADOODLES
GOLDENDOODLES
Top Breeder
Shots/worming/health guarantee
Great Family Pets
Stevensretrievers.com
618-390-2494

Legals

IN THE CIRCUIT COURT OF THE SEVENTH
JUDICIAL CIRCUIT,
SANGAMON COUNTY,
ILLINOIS
NOTICE
Case No. 2018MR0002289
Public Notice is hereby given that on
05/13/2018, Vanessa A. Hodgen will file a petition
in said court praying for the change of my name
from CHLOE ELIZABETH CHASE-SOMERES to
CHLOE ELIZABETH HODGEN pursuant to the
statute in such case made and provided. Dated:
this 29th day of March, 2018.
Signed:
Vanessa A. Hodgen

Pets

Pets

Richard Fries Easter
Bunnies, 10 wk babies
New-arrived, blood-
wormed, home-
raised, \$850-217-248-
8434

Legal

AKC Cocker Spaniels
Bred
\$1800-\$3000 males
5 months old
4th Generation
Show Dog Pedigree
Family raised
Phone calls only
217-528-3670

Did you know...
14%
in the share of
newspaper revenue
now coming from digital

SJR

For the
bargain
hunter
in all of us!

217-788-1330

Claims against the estate may be filed in the Of-
fice of the Clerk of the Circuit Court, Sangamon
County Court Complex, 200 South Ninth Street,
Springfield, Illinois 62781, or with the representa-
tive, or both, on or before September 21, 2018,
or if mailing or delivery of a notice from the rep-
resentative is required by §18-3 of the Probate
Act of 1975, 755 ILCS 5/18-3, three months from
the date the representative mailed or delivered
such notice, whichever is later. Any claim not
filed on or before that date is barred. Copies of a
claim filed with the Clerk must be mailed or de-
livered to the representative and to the attorney
within ten (10) days after it has been filed.
DATED this 18th day of March, 2018.
Sylvester Brown
Michael C. Connelly
1 North Old State Capitol Plaza, Suite 200
P.O. Box 1317
Springfield, IL 62705
Telephone: (217) 544-1144
E-mail: mcconnelly@springfieldlaw.com

Legals

IN THE CIRCUIT COURT
OF THE SEVENTH JUDICIAL
CIRCUIT,
SANGAMON COUNTY,
SPRINGFIELD, ILLINOIS

IN RE THE MARRIAGE OF
Dorlene M. Scoville
Petitioner
vs. No. 2018MR000082
Anthony E. Scoville
Respondent

NOTICE BY PUBLICATION
NOTICE IS GIVEN THAT Anthony E. Scoville, Re-
spondent, filed a Petition for Dissolution of Mar-
riage in said court. In said Court, seeking to dis-
solve the above-referenced marriage and for
other relief.
UNLESS YOU file your answer or otherwise file
your appearance in this case in the office of the
Clerk of this Court, Sangamon County Court
house Complex, 200 South 9th Street, Spring-
field, Illinois, on or before the 29th day of April,
2018, A JUDGMENT OF DECREE BY DEFAULT
MAY BE TAKEN AGAINST YOU FOR THE RELIEF
ASKED IN THE COMPLAINT.
CLERK OF COURT

Legals

Notice to Disadvantaged Businesses
Prairie State Packaging, Inc. (P.S.P.) P.O. Box
228, Joliet, IL 62431, Tel: 815-717-636-9000,
is seeking disadvantaged businesses for the City
of Springfield 33 FGS in handling Units Re-
moval and Replacement Project for subcontract-
ing opportunities in the following divisions of
work: Trucking, All interested and qualified
minority and female owned business should
contact: IN WRITING, (Certified Letter, Return Re-
ceipt Requested, Ed. Add in the above address
to discuss possible subcontracting opportunities.
All negotiations must be completed prior to
the bid opening on April 12, 2018.
(All bids will be evaluated Method of evaluating
proposals in order of importance:
1. Price and completeness of scope)
2. Ability to bond scope
3. Past experience with same scope
4. Satisfaction of owners on completed projects
5. Work at hand
6. Years in business performing similar scopes


Legals

Notice to Minority and Female Owned
Businesses
Trombin 12 Flatt & Sons Co., Inc. 2300 North 16th
Street, Springfield, IL 62702, (217) 544-3421 is
seeking qualified minority and female owned
businesses for the City of Springfield RFP19-03-
05 FY 2019 Self Care Project for subcontracting
opportunities in the following areas: Handling
Material. All interested and qualified minority
and female owned businesses should contact, IN
WRITING (Certified Letter, Return Receipt Re-
quested) Harrington Montgomery. All negotia-
tions must be completed by April 4, 2018 at
3:00 p.m. Proposal will be evaluated by price
ability to do the work and ability to meet re-
quired schedules.

In Loving Memory of
Sylvester Brown
4/2/1959 - 1/20/2018
Happy 1st Birthday in Heaven

Love,
Reppie, Josephine & Family

Memorials

In Memory Of
Roger W. (Bud) Wilson
Jack A. Brown
James R. Beck
Happy Easter

Family, Friends

Memorials

REMEMBERING
Paul Myers and
Bryan & Licky Thompson
Happy Easter

Family, Friends


Legals

IN THE CIRCUIT COURT OF THE SEVENTH
JUDICIAL CIRCUIT,
SANGAMON COUNTY,
ILLINOIS
NOTICE

Case No. 2018MR000054
Public Notice is hereby given that on 3/6/2018, I
will file my petition in said court praying for the
change of my name from IVA KATHLEEN TRAVIS
to KATHLEEN IVA TRAVIS pursuant to the state
act. In such case made and provided. Dated this
22nd day of March, 2018.
Springfield, IL
Signed:
IVA KATHLEEN TRAVIS

Legals

St. John's Hospital in Springfield intends to dis-
continue cardiac catheterization services at
Prairie Diagnostic Center, a large specialty ambu-
latory surgical treatment center (ASTC) and
supposed to do so is issued by the Illinois Health
Facilities and Services Review Board (HFSRB). We
anticipate the permanent discontinuation will
occur around June 30, 2018. The Hospital in-
tends to submit the required Certificate of Ex-
emption on or around April 2/2018 and after
submission, a copy of it and information about
the intended discontinuation of the facility may
be found on the HFSRB website at
hfsrb.org/astc/astc.htm. You may also contact Dr.
Charles Lacore at (217) 544-6464 ext 64572 at
St. John's Hospital with any questions or con-
cerns.

Happy Easter

Sally Milled, Love, Rosalee

Memorials

In Loving Memory
Norman E. Hussey
"Norm"
March 11, 1934 - January 26, 2018

Happy Easter

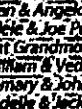
Sally Milled, Love, Rosalee

Legals

IN THE CIRCUIT COURT OF THE SEVENTH
JUDICIAL CIRCUIT,
SANGAMON COUNTY,
ILLINOIS
NOTICE

Case No. 2018MR000054
Public Notice is hereby given that on 3/6/2018, I
will file my petition in said court praying for the
change of my name from IVA KATHLEEN TRAVIS
to KATHLEEN IVA TRAVIS pursuant to the state
act. In such case made and provided. Dated this
22nd day of March, 2018.
Springfield, IL
Signed:
IVA KATHLEEN TRAVIS

Legals

All I have left are loving
memories of my family
Happy Easter

Rose Pearce, Charles McNeel
Coleen & Angelo Pedrucci
Adele & Joe Pedrucci
Great Grandmother Cox
William & Veda Lynn
Rosemary & Johnny Lynn
Rosalee & Jack Wheeling
Sally Milled, Love, Rosalee

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ST-JOURNAL

ON 1017 FERN RD
SPRINGFIELD, IL 62761



**HSHS
St. John's
Hospital**

March 13, 2018

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Joan M. Coffman
President and Chief Executive Officer
HSHS St. Mary's Hospital
1800 E. Lake Shore Drive
Decatur, IL 62521

RE: Proposed Discontinuation of Prairie Diagnostic Center, a single specialty ambulatory surgical treatment center ("ASTC")

Dear Joan:

I am writing to advise you of the subject above, and provide you an opportunity to submit an impact statement if you choose to. Prairie Diagnostic Center has two procedure rooms and has temporarily discontinued performing cardiac catheterization procedures, pending approval by the Illinois Health Facilities and Services Review Board of permanent discontinuation. The cardiac catheterization service is available nearby at St. John's Hospital and the planned discontinuation should not impact access to the service in this region. Upon discontinuation of the surgical service, the facility will continue to operate as a non-surgical outpatient center for cardiovascular specialties.

We anticipate permanently discontinuing the service after approval by the Illinois Health Facilities and Services Review Board, which we anticipate receiving by June 30, 2018. If you do choose to provide an impact statement, please advise us whether your facility has any restrictions or limitations which would preclude it from providing the cardiac catheterization service to our patients in the area. If you do not respond, we will assume the discontinuation has no impact on your facility.

Thank you.

Sincerely,

Charles L. Lucore, M.D., MBA
President & CEO
St. John's Hospital



**HSHS
St. John's
Hospital**

March 13, 2018

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Timothy D. Stone Jr.
President and Chief Executive Officer
Decatur Memorial Hospital
2300 N. Edward Street
Decatur, IL 62526

RE: Proposed Discontinuation of Prairie Diagnostic Center, a single specialty ambulatory surgical treatment center ("ASTC")

Dear Timothy:

I am writing to advise you of the subject above, and provide you an opportunity to submit an impact statement if you choose to. Prairie Diagnostic Center has two procedure rooms and has temporarily discontinued performing cardiac catheterization procedures, pending approval by the Illinois Health Facilities and Services Review Board of permanent discontinuation. The cardiac catheterization service is available nearby at St. John's Hospital and the planned discontinuation should not impact access to the service in this region. Upon discontinuation of the surgical service, the facility will continue to operate as a non-surgical outpatient center for cardiovascular specialties.

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Thank you.

Sincerely,

Charles L. Lucore, M.D., MBA
President & CEO
St. John's Hospital



**HSHS
St. John's
Hospital**

March 13, 2018

**VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED**

Edgar J. Curtis
President and Chief Executive Officer
Memorial Medical Center
701 N. 1st Street
Springfield, IL 62781

RE: Proposed Discontinuation of Prairie Diagnostic Center, a single specialty ambulatory surgical treatment center ("ASTC")

Dear Edgar:

I am writing to advise you of the subject above, and provide you an opportunity to submit an impact statement if you choose to. Prairie Diagnostic Center has two procedure rooms and has temporarily discontinued performing cardiac catheterization procedures, pending approval by the Illinois Health Facilities and Services Review Board of permanent discontinuation. The cardiac catheterization service is available nearby at St. John's Hospital and the planned discontinuation should not impact access to the service in this region. Upon discontinuation of the surgical service, the facility will continue to operate as a non-surgical outpatient center for cardiovascular specialties.

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Thank you.

Sincerely,

Charles L. Lucore, M.D., MBA
President & CEO
St. John's Hospital